To view printable form click here: Request for Prior Authorization

471-000-206 Form MS-77, "Request for Prior Authorization" and Completion Instructions

REQUEST FOR PRIOR AUTHORIZATION
Health and Human Services Finance and Support

G

Prior Authorization Number

PLEASE TYPE:

1. Client Name (Last, First, Initial)

2. Client Medicaid Case Number

NOTE: This authorization is void if the client is ineligible for Nebraska Medicaid or is enrolled in Nebraska Health Connection (NHC), the Medicaid Managed Care Program, at the time the service is provided. It is the responsibility of the provider to verify client Medicaid eligibility.

3. Provider Name

4. Medicaid Provider Number

5. Provider Street

6. City, State, Zip

7. Provider Phone No.
( )

8. **SERVICES TO BE AUTHORIZED**

	Procedure Code	Modifier	Units of Service	Unit Price	Description of Service	Do Not Complete Amount Authorized
a						
b						
c						
d						
e						

9. Name of Prescribing Practitioner

10. Prescribing Practitioner's License Number

11. Client in Nursing Facility/ICF-MR?
☐ Yes ☐ No

12. Rental Items Only

	Purchase Price	Date Delivered	NEW	USED
a)			☐	☐
b)			☐	☐
c)			☐	☐
d)			☐	☐
e)			☐	☐

13. Diagnoses

14. Date Delivered or Rental Period Requested
From ___ ___ ___ (Month Day Year) To ___ ___ ___ (Month Day Year)

15. Requesting Provider's Signature

16. Date of Request

MEDICAID USE ONLY

17. **Comments and/or Reasons for Denial:** (Denials may be appealed in writing within 90 days of the denial date by addressing a letter to the Director of Health and Human Services Finance & Support requesting a hearing and stating the basis for the appeal).

18. I certify that the listed goods or services are authorized under the rules and regulations of the Nebraska Medicaid Program.

Signature of Authorizing Agent

Date Authorized

19. HHS Local Office

Form MS-77 Instructions for Completion

Use: Form MS-77 is used to prior authorize payment for items as required by the Nebraska Medicaid Program (471 NAC 7-000). Copy this form for office use. Incomplete forms will be returned

Prior authorization may also be requested and issued using the standard electronic Health Care Services Review - Request for Review and Response transaction (ASC X 12N 278). For instructions, see Standard Electronic Transactions at 471-000-50. **Completion:** Providers shall complete Form MS-77 as follows:

1. **CLIENT NAME:** Enter the client's full name as listed on the Nebraska Medicaid eligibility card.
2. **CLIENT MEDICAID NUMBER:** Enter the client's eleven-digit Medicaid identification number as listed on the Nebraska Medicaid eligibility card.
3. **PROVIDER NAME:** Enter the name of the provider.
4. **MEDICAID PROVIDER NUMBER:** Enter the provider's eleven-digit Medicaid provider number.
5. **PROVIDER STREET:** Enter the provider's complete street address to which this authorization should be returned.
6. CITY, STATE, **ZIP:** Enter the provider's city, state and zip code to which this authorization should be returned.
7. **PROVIDER PHONE NUMBER:** Enter the phone number at which the person requesting the prior authorization may be contacted.
8. **SERVICES TO BE AUTHORIZED:** A maximum of five services can be requested on each prior authorization request. For each service requested, enter the information listed below:

   Procedure Code: Enter the procedure code.

   Modifier: Enter the procedure code modifier, if applicable.

   Units of Service: Enter the number of units requested.

   Unit Price: Enter the provider's charge for each unit of service being requested. Do not enter the "total" charge unless only a single item is requested.

   Description of Service: Enter a description of each service requested, including brand name and model number, if applicable.

   Amount Authorized: DO NOT COMPLETE. This field will be completed by Medicaid Division staff, if required.

9. N**AME OF PRESCRIBING PRACTITIONER:** Enter the full name of the practitioner who prescribed the services.
10. **PRESCRIBING PRACTITIONER'S LICENSE NUMBER:** Enter the license number of the prescribing practitioner. License number listings are available from HHS upon request.
11. **CLIENT IN NURSING FACILITYACF/MR:** Indicate if the client was residing in a nursing facility or ICF/MR on the date of service.
12. **RENTAL ITEMS ONLY:** On the line corresponding to the rental item requested in field 8, enter the purchase price, the date the rental item was initially provided to the client, and whether the item was new or used when delivered.
13. **DIAGNOSES:** Enter a ICD-9 diagnosis code from the practitioner's prescription.
14. **DATE DELIVERED OR RENTAL PERIOD REQUESTED:**
    For rentals - Enter the "FROM" and 'TO' dates of the rental period being requested in month/day/year format.
    For purchases - If the service has already been provided at the time the prior authorization request is submitted, enter the delivery date as the "FROM" date in month/day/year format. If the prior authorization request is for a service not yet provided, leave blank.
15. **REQUESTING PROVIDER'S SIGNATURE:** Enter the signature of the provider or the provider's authorized representative.
16. **DATE OF REQUEST:** Enter the date the provider submits the request.

FIELDS 17-19: Do not complete. This section will be completed by Medicaid Division staff.
Distribution: Submit the completed Form MS-77 with the required documentation of medical necessity to: Health and Human Services Finance and Support, Medicaid Division, PO. Box 95026, Lincoln, NE 68509-5026.

If the services are authorized, Medicaid Division staff will sign and date Form MS-77 and return one copy to the provider. If the services are denied, Medicaid Division staff will note the denial in Field 17 and return one copy of Form MS-77 to the provider. Denials may be appealed in writing within 90 days of the denial date by addressing a letter to the Director of Health and Human Services Finance & Support requesting a hearing and stating the basis for appeal.